

PROVIDING INTEGRATED SERVICES FOR PERSONS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

IMPLEMENTATION PLAN – PHASE I

Developed by the:
ARIZONA INTEGRATED TREATMENT
CONSENSUS PANEL

*Funded by a Knowledge Development Grant From:
The Substance Abuse Mental Health Services Administration*

Arizona Department of Health Services
Division of Behavioral Health Services
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Preface

The information and recommendations included in this report are the results of a year-long process of the Arizona Integrated Treatment Consensus Panel. Activities included review of literature, training provided by national experts in integrated treatment, discussion of the current system in Arizona and development of long term plans for the implementation of services for persons with co-occurring mental health and substance abuse disorders.

The Phase I Implementation Plan should be viewed as the first step - a framework for beginning an ongoing and inclusive process focused on attaining system change over the long term. Phase II of the process will expand the involvement and planning statewide. The actual implementation of system change must be a planned, thoughtful process with actions that will evolve and be refined as Arizona policy makers, administrators, service providers, consumers and family members become more aware of the options and opportunities.

ACKNOWLEDGEMENTS

The Implementation Plan for Providing Integrated Treatment Services for Persons with Co-occurring Mental Health and Substance Abuse Disorders was developed through the commitment of many individuals who share a belief that individuals with co-occurring disorders will attain improved outcomes through the integration of services for both disorders. Special recognition and acknowledgement of their specific efforts in the development of this plan goes to:

- ◆ The *Integrated Treatment Consensus Panel Members* who openly shared their ideas, expertise and creativity to help ensure persons with co-occurring disorders have the opportunity for the best treatment possible through development of integrated services.
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- ◆ *Dr. Kim Mueser* who provided through his writings and a training seminar great insight and direction in the philosophy and techniques of providing integrated treatment.
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INTRODUCTION

Background

In Arizona as well as elsewhere, at least 50%¹ of persons with identified psychiatric disorders also have a co-occurring substance use disorder, and at least 35%² of persons with an identified substance use disorder also have a psychiatric disorder. Historically, treatment of these conditions has followed a model of sequentially addressing the needs of the client through parallel systems of care. Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes that co-occurring disorders are the expectation, not the exception. The development of a limited number of specialized “dual diagnosis” programs will not address the needs of a majority of our clients with co-occurring psychiatric and substance use disorders. A major change in the behavioral health system is necessary.

Arizona Integrated Treatment Consensus Panel

Through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal Department of Health and Human Services, the ADHS/BHS formed the Arizona Integrated Treatment Consensus Panel³ (AITCP) in January 1999 to initiate this change process. The AITCP included representatives of the substance abuse and mental health service systems in Arizona. Consumers, family members, providers of service, advocates, Value Options, CPSA and the Department of Health Services were represented on the AITCP. See Appendix A for a complete list of Consensus Panel Members.

The grant identified the following objectives of the initiative: 1) convening an advisory group of key stakeholders on a monthly basis; 2) conducting knowledge exchange sessions with local and national experts in order to identify exemplary practices regarding integrated treatment; 3) using group consensus process building methods to identify the local model and barriers to implementing integrated treatment; 4) developing a work plan to overcome the barriers and implement the integrated treatment model, 5) disseminating the results statewide, and 6) monitoring implementation and results.

For purposes of this initiative, individuals with co-occurring illnesses includes people with:

- Substance abuse (DSM definitions) and/or dependence disorders and a general mental health disorder or a serious mental illness.
- Serious mental illness and substance abuse or substance dependence;
- Psychiatrically complicated substance abuse or substance dependence

The psychiatric community views co-occurring disorders as a continuum of disorders characterized by severity of symptoms and functional impairment. This model supports both interventions to stabilize drug/alcohol abuse in seriously mentally ill adults, as well as

¹ Gain Center, 1997

² Broomer, *Archives of General Psychiatry*, 1997

³ Integrated Treatment has been defined by Robert Drake, M.D., Ph.D. and Kim Mueser, Ph.D. as follows: “The essence of integration is that the same clinicians or teams of clinicians, working in one setting, provide both mental health and substance abuse interventions in a coordinated fashion. Clinicians take responsibility for combining the interventions so that they are tailored for the presence of comorbidity.” *Psychosocial Approaches to Dual Diagnosis*, Robert E. Drake, M.D., Ph.D. and Kim T. Mueser, Ph.D, New Hampshire-Dartmouth Psychiatric Research Center, 1-8-99, p.9.

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interventions to treat psychiatric disorders that do not qualify as serious mental illness in the substance abuse population.

Methodology

The Integrated Treatment Consensus Panel (AITCP) met monthly to define the desired integrated system of services for Arizona. The initial work of the Panel included definition of operating rules (See Appendix B) and process to be followed.

The ADHS/DBHS and the AITCP provided documentation from other states about research and program design for implementing integrated treatment services. The AITCP identified, reviewed and discussed extensive professional literature and other materials specifically addressing the methodology, skills and philosophy needed to effectively treat and support persons with co-occurring disorders. A list of the documentation reviewed is included in Appendix C.

The AITCP participated in a training seminar provided by Dr. Ken Minkoff about the principles of a system of integrated services and the implementation experience in Massachusetts. Dr. Minkoff also reviewed the Arizona principles and draft goals and objectives and provided recommendations for enhancements. Dr. Kim Mueser provided specific training regarding a treatment model for integrated services.

The AITCP began the process by defining principles, goals, objectives and strategies for implementing integrated treatment services in Arizona. Once the overall goals had been defined, the AITCP formed four committees to develop specific implementation recommendations regarding Department of Health Services Policy, the Continuum of Care, the Competencies for Providing Integrated Treatment, and the Funding Mechanisms.

Throughout the process, the AITCP evaluated each meeting and evaluation results were reviewed by the facilitator to ensure areas of concern were addressed in future meetings. A final report of the evaluation will be provided by the University of Arizona.

Finally, each Committees documented their work and developed specific recommendations. The AITCP reviewed the draft recommendations and reached consensus on the Implementation Plan.

LONG TERM PLAN FOR INTEGRATED TREATMENT

The AITCP developed the Vision, Principles, Goals, Objectives, and Strategies for the long-term implementation of integrated treatment services in Arizona. The Hallmarks of Success were represent milestones that will demonstrate progress toward the system envisioned by this plan.

Vision

A comprehensive system of care with the capacity to effectively deliver simultaneous mental health and substance use disorder assessment and treatment at every level of care is available and accessible to persons with co-occurring disorders.

Principles

The AITCP developed the following principles to guide definition and implementation of an integrated system of care for persons with co-occurring mental health and substance abuse disorders. Principles defined in the Report of The Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project, Dr. Kenneth Minkoff, Panel Chair, were used as a framework for these principles.

1. Integrated Assessment, Treatment and Recovery – Psychiatric and substance disorders, regardless of severity, tend to be persistent and recurrent, and these disorders co-occur with sufficient frequency and complicate each other so that a continuous and integrated approach to assessment, treatment and recovery is required. Regardless of the location of initial and subsequent clinical presentations, integrated services should be available to anyone who would benefit. Assessments must be inclusive of both disorders and must include understanding the individual in their own context.
2. Use of Existing Services and Programs – A comprehensive integrated service system should be created by building on the strengths of the current system, services and programs to incorporate the principles and model of integration. When needed, new services and programs will be developed. New services and programs will be evidence based and / or will be innovations that have a high likelihood of success.
3. Continuity of Care – The comprehensive integrated service system will provide early access to continuous integrated treatment relationships which can be maintained over time, through multiple episodes of acute and sub-acute treatment and follow-up care. Maintaining these relationships is independent of any particular treatment setting.
4. Dual Primary Treatment – The recommended treatment approach is integrated dual primary treatment, in which:
 - a) Each disorder receives phase-specific and appropriately intensive simultaneous treatment that takes into account the level of severity and engagement for each disorder, and any complications resulting from the co-occurring disorders.
 - b) Each individual has a primary treatment relationship with an individual who coordinates ongoing treatment interventions for all co-occurring disorders.
 - c) Each individual receives treatment for co-occurring disorders in the setting or service system that is most appropriate to the needs of the individual.

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- d) Each individual has access to clinicians or multidisciplinary teams who have expertise in both mental health and substance abuse treatment as well as expertise in mental health / substance abuse co-occurring disorders. When the individual has a serious mental illness, the team will include expertise specific to treatment for serious mental illness.
 - e) When the individual has a serious mental illness and a co-occurring addictive disorder, integrated treatment for both disorders will be provided “by the same clinicians or teams of clinicians, working in one setting, providing both mental health and substance abuse interventions in a coordinated fashion.”⁴
 - f) Each individual is encouraged to include family members or significant others in the treatment planning and service delivery process.
- 5. Empathic Relationship – The single most important factor for recovery from co-occurring illnesses is an empathic service relationship in which the individual experiences the hope of dual recovery and is considered to have the potential to achieve dual recovery.
 - 6. Individualized Service Strategies – Persons with co-occurring disorders may be at different phases of recovery⁵ for each disorder, and should receive phase-specific treatment for each disorder. Persons with co-occurring disorders need a judicious combination of supportive case management and care, and empathic detachment and empowerment. Harm reduction, self-management and disease recovery strategies should all be used as appropriate.
 - 7. Co-occurring Medication and Substance Use – It is imperative that persons with co-occurring psychiatric and substance disorders are provided access to effective medications for both disorders. For example, the presence of substance use, abuse, or dependence does not preclude the provision of psychotropic medications.
 - 8. Unconditional Commitment - There will be a long term, unconditional commitment to the individual. Expectations will be realistic and individuals will be provided a welcoming environment initially and at all times thereafter.
 - 9. Cultural Competency – Persons with co-occurring disorders will receive culturally relevant care that addresses and respects language, customs, values and mores and that has the capacity to respond to the individual’s unique family, culture, traditions, strengths and gender.
 - 10. Effectiveness – The services will be outcome based as defined by the consumer and will provide evidence of effectiveness through the appropriate use of periodic outcome evaluations and consumer satisfaction assessments. Measures should include progress through treatment phases, and multi-dimensional psychiatric, substance and functional outcomes.

⁴ Drake, Robert E., MD, Ph.D. and Kim T. Mueser, Ph.D., Psychosocial Approaches to Dual Diagnosis, New Hampshire-Dartmouth Psychiatric Research Center, 1-8-99, p.9.

⁵ For purposes of this document, recovery is defined as a process by which an individual with a persistent, possibly disabling disorder, recovers self-esteem, self-worth, pride, and dignity and meaning through acquiring increasing ability to maintain stabilization of the disorders, by developing symptom management skills, and the capacity to maximize functioning within the constraints of the disorder.

Goals, Hallmarks of Success, Objectives and Strategies

- Goal A: The quality of life of individuals with co-occurring disorders is improved.
- Goal B: Consumers and family members are involved in the treatment and recovery process.
- Goal C: The service delivery system provides a safe, consistent, user friendly, predictable environment.
- Goal D: Integrated treatment services are readily available.
- Goal E: The continuum of care is integrated, individualized, flexible in design and planning, and supportive of an ongoing treatment relationship.
- Goal F: Administrative functions across government entities, provider organizations and collaborative agencies support the principles of integrated treatment and a fully integrated, accessible system of services.
- Goal G: Funding for integrated treatment is sufficient to meet the behavioral health needs of individuals seeking treatment for co-occurring disorders.
- Goal H: Integrated treatment services are provided by qualified and effective personnel.

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GOAL A: THE QUALITY OF LIFE OF INDIVIDUALS WITH CO-OCCURRING DISORDERS IS IMPROVED.

Hallmarks of Success

- ⇒ Decrease in incarceration rates
- ⇒ Reduction in drop out rate of treatment
- ⇒ Increase length of time between relapse
- ⇒ Decrease unplanned crisis hospitalization
- ⇒ Increase avoidance of hospitalization
- ⇒ Maintenance of sobriety
- ⇒ Increased social adaptability
- ⇒ Stable living environment
- ⇒ Reduction in homelessness
- ⇒ Improved living skills as defined by the consumer and agreed to in the ISP
- ⇒ Decrease in crisis episodes
- ⇒ Increase in opportunity for early intervention
- ⇒ Decrease in suicides resulting from overdose
- ⇒ Increase in positive social contacts (non-criminal, non-using)
- ⇒ Increase in the individuals ability to cope in social situations / use of appropriate support systems (self report)

Objective 1: Individuals have the opportunity to explore and identify (with or without help) their goals and to achieve their goals.

Strategies:

- a) Treatment programs will ensure the basic relationship is maintained even if the individual is unable to respond to the treatment plan, until the individual is ready or willing to respond
- b) Treatment staff will provide a courteous, welcoming attitude
- c) Emphatic relationships will be developed and maintained
- d) Treatment programs, protocols, and clinical standards will include “no shaming” regardless of the readiness of the individual to participate in treatment
- e) Provide assistance and education for individuals in meeting their basic needs (food, shelter, etc.)
- f) Assist individuals in connecting with other resources
- g) Identify incentives to assist in enhancing the likelihood of compliance with treatment

Objective 2: Individuals understand and actively participate in wellness as a life long process.

Strategies:

- a) Provide access to and encouragement to use sponsors, mentors, and other supports
- b) Non-compliance and relapse is addressed as an expected part of the overall treatment process

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Objective 3: Individuals report an increase in their ability to manage symptoms and report a decrease in symptoms.

Strategies:

- a) Include symptom prevention and early intervention strategies in Integrated treatment programs
- b) Provide relapse management⁶ and relapse prevention skills training for consumers
- c) Implement specific interventions to promote movement from one stage of treatment to the next

Objective 4: Individuals have an increased level of functioning.

Strategies:

- a) Implement methods to ensure crisis / hospital services are used in an optimal and stabilizing manner
- b) Reduce the use of hospital, jail and crisis systems
- c) Develop options for increasing independence in living
- d) Implement methods for increasing consumer participation in the community such as volunteer work, paid work, clubs

GOAL B: CONSUMERS AND FAMILY MEMBERS ARE EFFECTIVELY INVOLVED IN THE ASSESSMENT, TREATMENT PLANNING, DELIVERY AND RECOVERY PROCESSES.

Hallmarks of Success

- ⇒ Family satisfaction with the services: (families and individuals with disorders decide how to define satisfaction)
 - is the patient / consumer managing his/her symptoms?
 - has the family received opportunities for education
 - has the system been accessible
 - have the consumer and family been consulted by the treatment team on an ongoing basis
 - does the family know who to talk to regarding their family members treatment.
- ⇒ Participation with individual support systems
- ⇒ Realistic improvement in relationship
- ⇒ Increase in symptom management resulting in a reduction in symptoms
- ⇒ Improved interpersonal relationships
- ⇒ Increased involvement in the development of the ISP (as appropriate)
- ⇒ Increase involvement in education opportunities
- ⇒ The service system is responding to the needs of the consumer and family as per the ISP
- ⇒ Improvement in the family functioning

⁶ Relapse management includes symptoms of both substance use disorders and mental health disorders.

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Objective 1: Information will be provided to family members regarding the facts about the diagnosis, treatment, medication and side effects, prognosis, legal issues, family access to information, crisis plan, how to support client, support services, access for client, and understanding realities of the disorder (confidentiality will not be violated).

Strategies:

- a) Make counseling available including joint sessions available if needed
- b) Actively pursue families input in the assessment process
- c) Re-evaluate family involvement at various levels
- d) Make reasonable consideration of family expectations

Objective 2: The minor children of consumers will be provided information and support.

Strategies:

- a) Make counseling available including joint sessions if needed
- b) Provide for follow-up and use of support groups
- c) Include specific actions in Individual crisis plans to protect children during periods of relapse

Objective 3: Family members and others who are significantly involved in the life of the individual will be included in the treatment planning process.

Strategies:

- a) Family members are an important resource in the treatment of persons with serious mental illness and co-occurring addictive disorders. Research overwhelmingly shows that when families are informed and take an active part in treatment decisions, consumer outcomes are improved.
- b) Families need support, education, and involvement to be effective.
- c) The family's unique knowledge of and relationship with the consumer can be a significant help in determining the best course of treatment.
- d) Family members and others significantly involved in a consumer's life should be included in the Individual Service Planning (ISP) process as equal members and integral parts of the treatment team.
- e) Families should be provided with sufficient education in all facets of the illness to allow them to be effective in the ISP process.
- f) Family members and others significantly involved in the consumer's life are treated with respect.
- g) Professionals are obligated to accept information from family members or others who function in care giving roles or are significantly involved in a consumer's life.
- h) Treatment providers are responsible for making known to caring families and caregivers any information necessary to the ongoing care of persons with serious mental illnesses, however, a patient's personal or private information should not be subject to disclosure by professionals. In the event a patient objects to disclosure, the provider should use best clinical judgment in determining how best to proceed.
- i) Families and others significantly involved in a consumer's life can provide helpful input and feedback as to relevance of the ISP and progress the consumer is making in meeting ISP goals.

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- j) The treatment team should support and work toward the consumer's having a positive relationship if possible with family and others significantly involved in his/her life.
- k) Consumers and family members are treated with compassion, dignity and respect, and are the primary facilitators of mutually agreed upon treatment team goals. The public mental health system should support, never supplant families. When treatment is long term, or unsuccessful, it is the consumer and family who will suffer havoc and pain.
- l) Family advocacy needs to be encouraged. Where the public or private mental health system is understaffed or under-financed, where services are uncoordinated, or where other problems impede service delivery, the family's involvement and advocacy are essential to ensure the best possible treatment.
- m) Behavioral health professionals should endeavor to strengthen family relationships and empower all involved members. Sometimes, because of stigma and lack of information regarding serious mental illnesses, the family is not involved. This absence does not usually occur as a result of a lack of caring or concern. When families are respectfully involved in ways they feel to be empowering, their approach to the patient and the treatment system changes.
- n) In cases where the consumer does not want the family involved, efforts should be made to help the consumer understand that outcomes are likely to be improved if all interested parties work together. Extensive education and support are required. This includes helping the consumer to understand that neither he nor his or her family is to blame for the illness and how important the family is to the consumer's recovery.
- o) When the consumer, family and professionals work together, better treatment can be provided and the patient's outcome will be improved.
- p) Consumers and family members should be encouraged to participate in the educational process of professionals and providers who treat or work with persons with brain disorders.
- q) When an individual lacks capacity and competence because of a serious mental illness and a co-occurring substance use disorder, the substitute judgment of a family member or significantly involved other, subject to sufficient safeguards and frequent review, may be justified in determining treatment .
- r) Caregivers, service providers, and consumers must work collaboratively to develop plans for advance directives that will guide a consumer's treatment, services, and supports in the future as needed.
- s) The ethics of best professional practice dictate that behavioral health professionals have a responsibility to share information as clinically appropriate with patients, family members, and others significantly involved in the life of the patient or client.

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GOAL C: THE SERVICE DELIVERY SYSTEM PROVIDES A SAFE, CONSISTENT, USER FRIENDLY, PREDICTABLE ENVIRONMENT

Hallmarks of Success

- ⇒ Decrease in staff turnover
- ⇒ Customer satisfaction
- ⇒ Reduction in the drop-out rate
- ⇒ Reduction in the number of changes in primary therapist for an individual
- ⇒ Decrease in broken appointments by the consumer and / or the staff
- ⇒ Increased community based / home based treatment available

Objective 1: Develop and adhere to best practice standards related to providing services for persons with co-occurring disorders.

Strategies:

- a) Identify and review best practices
- b) Prepare Arizona Practice Standards draft
- c) Provide opportunity for broad based review of the draft
- d) Define implementation steps
- e) Define training needs and training opportunities
- f) Incorporate into Quality Review and Monitoring Processes

Objective 2: No client is denied eligibility for service because of the presence of a co-occurring psychiatric condition and the use of psychotropic medication usage or substance use.

Strategies:

- a) Organizations, networks, agencies, and private practitioners initiate an administrative review of contracts, policies and procedures, marketing materials, or other rules, etc. to eliminate overt contradictions. AHCCCS, ADHS/DBHS and RBHAs conduct similar administrative reviews
- b) Review grievance and appeal records, customer service logs, and other consumer data to identify trends. Use this information to build staff training modules. (Systemic and agency by agency)
- c) Build training modules which focus on specific impacts (for example-a counselor at a residential "CD" facility should have an understanding of proper medication usage, be aware of the specific medication that his/her client may use, and appreciate the difference between appropriate use of medication and relapse behavior). Included should be general education, specific issues, and attitudes.
- d) Training should be aimed at a variety of audiences, line staff, supervisors, non-clinical staff, MD's, case managers, PBHP's, consumers, Board of Directors, etc.
- e) Establish a CQI process to assess the quality of SMI determinations.
- f) Clinical supervisors review cases and interventions with supervisees to assure appropriate clinical decision making.

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- g) Quality assurance committees proactively develop plans to support policy.
- h) Individuals will not be terminated from a treatment program for showing symptomology of their disorder (relapse).

Objective 3: Every client requesting or being referred to addiction services can receive integrated treatment.

Strategies:

- a) All substance abuse treatment providers will develop the capacity to provide integrated treatment within three years
- b) Provide integrated treatment planning services for all clients determined to be in need of integrated treatment
- c) All clients determined to be in need of integrated treatment services will be assigned to a clinician trained in the assessment and treatment of co-occurring disorders. This clinician will be the single point of contact for the client and will ensure that integrated treatment is provided

GOAL D: INTEGRATED TREATMENT SERVICES ARE READILY AVAILABLE AND ACCESSIBLE.

Hallmarks of Success

- ⇒ Length of time from referral to first contact is consistent with guidelines
- ⇒ Number and type of service needed versus provided / available throughout the treatment process
- ⇒ Increase in the number of service providers providing dual diagnosis integrated treatment
- ⇒ Policy supports integrated treatment
- ⇒ Fifty percent of the front line workers are trained in dual diagnosis
- ⇒ Baseline needs assessment information with periodic reassessment
- ⇒ Evidence of involvement in the plan / ISP
- ⇒ Individuals are specifically trained in conducting assessments for co-occurring disorders
- ⇒ All geographic areas provide all the ASAM criteria options
- ⇒ Appropriate assessment for co-occurring disorders is available

Objective 1: Provide access to integrated services at times and places that are convenient to the consumer:

Strategies:

- a) The following access points will be provided for screening and referral:
 - school
 - crisis / emergency rooms
 - state agencies
 - therapists

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- courts
- civil court
- behavioral health providers
- substance abuse providers
- vocational rehabilitation service providers
- b) All mental health and substance abuse providers provide outreach components for persons within the system for continuous engagement and follow-up
- c) Provide training for practitioners in Motivational Interviewing and other client-centered methods
- d) All access points are available regardless of presenting disorder
- e) Provide 24 hour phone screening for entry
- f) Deliver crisis services within 2 hours of contact
- g) Provide 24 hour urgent services
- h) Provide routine services within 7 days
- i) Individual communities are involved in provision of comprehensive services: medical care, substance abuse, mental health, social services, education, law enforcement, job training, counseling, vocational and child care

Objective 2: Provide geographic availability of integrated treatment services.

Strategies:

- a) Establish a “No wrong door” policy regarding access to services
- b) Identify options for providing geographic availability
- c) Provide transportation services to evaluation sites
- d) Provide mobile evaluation services
- e) Cross training of assessment staff
- f) Crisis / urgent care needs to provide acute stabilization / respite or in-home services
- g) Routine care is available during evening and weekend hours
- h) Create linkages to the current private system and community mobilization models

Objective 3: Regardless of the type of eligibility for publicly funded services, persons seeking integrated treatment will have access to the same evaluation and treatment benefit package. (Note: Persons eligible for services via Medicaid funding, state funding or other public funding may access the same service package.)

Strategies:

- a) Provide screening and assessment with clinicians trained in both disorders
- b) Accessibility will be greatly enhanced with one funding package. Funding should follow each person, not category.
- c) Provide better training on engagement skills for practitioners through training (meeting people at the level they are, attitudes regarding non-compliance, non-motivation, etc.
- d) All providers should have easy entrance, exit, re-entry policies and processes
- e) At intake sites, provide a clear understanding of the commitment process
- f) Work with the legislature to improve Title 36
- g) Integrated treatment should be an outcome of going through the Title 36 process when the individual has a co-occurring disorder

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Objective 4: Integrated treatment services will be sensitive to all aspects of the individual's culture as defined by him/her.

Strategies:

- a) Include standards regarding cultural competency in the integrated treatment core competencies
- b) Establish training courses to achieve cultural competency in integrated treatment
- c) Include assessment of cultural competence status in the integrated treatment agency self assessments
- d) Implement methods to monitor and evaluate culturally competent integrated treatment service delivery
- e) Provide opportunities to highlight culturally competent strategies implemented in integrated treatment programs

GOAL E: THE CONTINUUM OF CARE IS INTEGRATED, INDIVIDUALIZED, FLEXIBLE IN DESIGN AND PLANNING, AND SUPPORTIVE OF AN ONGOING TREATMENT RELATIONSHIP.

Hallmarks of Success			
Integration: ⇒ There is one Individual Service Plan ⇒ Joint staffings are held ⇒ The clinician or clinical team can treat both disorders ⇒ Reduction in the drop out rate ⇒ Consistency in treatment provider		Supportive of the ongoing treatment relationship: ⇒ The psychiatrist, clinician and clinical team are available to the consumer ⇒ Response is welcoming (Note – identify strategies for the rest of the system to encourage and validate the need for this relationship) ⇒ The relationship continues ⇒ The system policy and training supports the ongoing treatment relationship ⇒ Reduction in staff turnover ⇒ Agencies promote retention and methods to maintain ongoing treatment relationships	
Continuum: ⇒ Number of components available	Individualized: ⇒ There is a clear connection between assessment and the plan ⇒ The ISP is followed ⇒ The consumer is involved in the development of the ISP ⇒ Consumer satisfaction	Flexible in Design: ⇒ The process follows a CQI methodology ⇒ Services are available when needed and where needed ⇒ Programs are consistent with cultural, racial, and gender considerations	

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Objective 1: A full continuum of care is provided including the following components: outreach and prevention, day treatment, residential treatment, with community programs as part of the continuum of wellness to provide programs which meet the needs of individuals. (See page 23 for a description of the full continuum of service)

Strategies:

- a) Orient services to long term treatment if needed, not just a crisis response
- b) Provide long-term support services
- c) Facilitate coordination of care among providers across the continuum of care including the Arizona State Hospital, other inpatient services, and community providers
- d) Modify accounting systems and management information systems to allow for integrated treatment
- e) Clearly define the statutory requirements regarding confidentiality, the legal options available to clinicians for sharing information with other clinicians
- f) Implement a process to ensure all clinicians have an understanding of confidentiality requirements and options

Objective 2: The integrated service system will support the development and maintenance of the “long term continuous clinical relationship”.

Strategies:

- a) Implement policy and practice which ensure that changes in level of care do not require a change in team or provider
- b) Provide the capacity for providers to add services when necessary within their agency or through the development of partnerships with other providers
- c) Implement policy and practice that supports individuals remaining in programs based on their individual needs; i.e. relapse does not result in removal from an integrated treatment program and improvement does not result in removal from an integrated treatment program
- d) Implement incentives to enhance the compliance of providers in delivery services in a manner consistent with the principles
- e) Implement policy and a process which supports allowing individuals to stay in treatment as long as needed

Objective 3: Treatment services will be individualized.

Strategies:

- a) Develop and implement comprehensive integrated initial treatment plans which incorporate the consumer's goals, preferences and needs
- b) Ensure the Plan identifies appropriate treatment for identified needs
- c) Provide the consumer and family, as appropriate, education about the disorders
- d) Make appropriate referrals to address all of the individual's needs

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GOAL F: ADMINISTRATIVE FUNCTIONS ACROSS GOVERNMENT ENTITIES, PROVIDER ORGANIZATIONS AND COLLABORATIVE AGENCIES SUPPORT THE PRINCIPLES OF INTEGRATED TREATMENT AND A FULLY INTEGRATED, ACCESSIBLE SYSTEM OF SERVICES.

Hallmarks of Success

- | | |
|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| ⇒ Retention of clients | ⇒ Funding among agencies is pooled |
| ⇒ Increased level of functioning of clients | ⇒ There is a clear definition of the lines of authority |
| ⇒ Provider satisfaction | ⇒ The system provides incentives for collaboration |
| ⇒ Increased ability to meet individuals needs through collaboration | ⇒ There is an ability to share and use information |
| ⇒ A system exists to identify, document and address unmet need | ⇒ Coordinating committees exist |
| ⇒ Multiple agencies are involved and collaborating | ⇒ Policies and procedures promote and support integrated treatment |
| ⇒ Credentialing criteria includes requirements to collaborate and support the principles of integrated treatment | ⇒ Reduction in other systems costs (emergency room costs) |
| ⇒ Intergovernmental Agreements exist among the agencies. | ⇒ There is one treatment plan. |

Objective 1: All stakeholders have an understanding of and commitment to the principles and goals of integrated treatment.

Strategies:

- a) Hold a public forum to present and obtain buy-in to the principles and goals
- b) Publish the principles and goals on the web site, in newsletters, and other publications as available
- c) Create ongoing forums for sharing information, developing and implementing strategies, and sharing best practice standards
- d) Create an integrated treatment advisory committee. Ensure representation includes consumers, family members, and providers representing both individuals with substance abuse disorders and individuals with mental health disorders
- e) Conduct surveys, focus groups and other public forums to provide an opportunity for broader input to the plan, services, and results

Objective 2: Use state of the art technology to manage and deliver integrated treatment services at all levels.

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Strategies:

- a) Using electronic sharing of information, ensure clinicians are aware of an individual's prescription drug use
- b) Evaluate the current technology available
- c) Establish a technology standard and develop a plan and funding to bring the state, RBHAs and providers to that standard
- d) Track clinical programs and utilization
- e) Review the Cedar System to determine the capacity to track information about both disorders
- f) Develop the capacity within information systems to identify individuals with co-occurring disorders
- g) Create an interactive system between / among providers
- h) Provide for on-line access to policy, forms, and technical assistance

Objective 3: Streamline administrative functions throughout the delivery system.

Strategies:

- a) Create a billing algorithm and "cook book" for everyone to use – using the technology available
- b) Conduct a review of forms and identify options for standardizing the forms for use system wide to increase the ability to share information
- c) Explore options for use of deemed status in licensing
- d) Identify and remove the licensing barriers
- e) Implement a performance improvement system to monitor integrated treatment

GOAL G: FUNDING FOR INTEGRATED TREATMENT IS SUFFICIENT TO MEET THE BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS SEEKING TREATMENT FOR CO-OCCURRING DISORDERS.

Hallmarks of Success

- ⇒ No waiting lists
- ⇒ Services are available and are based on level of acuity
- ⇒ Increased public support for individuals with co-occurring disorders
- ⇒ Increase in information to and support from elected officials
- ⇒ Reduction in crisis utilization at all levels
- ⇒ Reduction in the repeated use of crisis services
- ⇒ Reduction in caseload sizes
- ⇒ The information systems are user friendly and compatible
- ⇒ Full benefit package is provided based on need regardless of eligibility
- ⇒ Increase in funding for quality training
- ⇒ Adequate funding for program evaluation (outcome and process) as part of CQI is provided

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Objective 1: Expand funding resources

Strategies:

- a) Support the Mental Health Task Force recommendations
- b) Support inclusion of the Integrated Treatment Principles in statute
- c) Support legislative efforts to implement full parity
- d) Support funding increases for non-SMI and non-Title XIX eligible persons
- e) Link funding requests to successful outcome measures
- f) Define a method to creatively fund the system
- g) Develop additional options
- h) Broaden the funding base and utilize resources available from cities, towns, counties, state and federal government, private insurance, tribal governments

Objective 2: Funding is flexible, available, and consistent with the chronic nature of the illness. Funding structures support access to a full continuum of care and individualization of services.

Strategies:

- a) Define outcomes and establish process for measuring outcomes
- b) Define a funding structure that supports all the clinical programs in the continuum
- c) Create incentives for good treatment and wellness
- d) Develop relationships with social security, AHCCCS, VR, DDD, Veterans Administrations, etc. to help identify and fund the full continuum through sharing of resources, development of joint ventures, and sharing of risk.
- e) Develop funding structures that are risk based depending on treatment outcome

Objective 3: There is more efficient use of current funding.

Strategies:

- a) Identify opportunities for more efficient use of funding by matching service intensity with need to get the most cost effective appropriate service
- b) Identify the current different funding streams utilizing state and federal dollars regarding treatment for individuals that may be at risk of co-occurring disorders.
- c) Invite ongoing dialogue with these different agencies and bureaucratic entities to identify their specific needs, what it is they are already doing , and how we can work more collaboratively to assist in meeting the client's and family and agency needs
- d) Invite ongoing dialogue with clients and families about their experience with and impressions of service coordination among the different agencies and entities
- e) Identify areas of duplication of effort and develop a plan of action to begin to and ultimately eliminate this type of effort.
- f) Develop a top down, bottom up across agency attitude to the concept of "the team" when working on behalf to the client and family (e.g. ICMP team).

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Objective 4: Establish and implement a public awareness campaign to provide to the general public and to targeted audiences information regarding co-occurring substance abuse and mental illness and the benefits of integrated treatment.

Strategies:

- a) Develop public awareness campaign on the disorders and access to treatment
 - Print media
 - Public Service Announcements
- b) Seek grant funding to fund the public education program
- c) Plan the public awareness campaign after the behavioral health community has been trained
- d) Develop a Speakers Bureau together with others (AAMI, Consensus Panel, NAADAC, Recovering Communities, etc.)
- e) Provide education about the changes needed to Title 36, Arizona Revised Statutes
- f) Include in the campaign for targeted audiences the importance of recognizing co-occurring disorders
- g) Provide data on cost benefit
- h) Provide information about harm reduction / integrated treatment
- i) Include the need for multiple treatment interventions

GOAL H: INTEGRATED TREATMENT SERVICES ARE PROVIDED BY QUALIFIED AND EFFECTIVE PERSONNEL WITH SPECIFIC COMPETENCIES TO PROVIDE INTEGRATED TREATMENT.

Hallmarks of Success

- ⇒ Reduction in staff turnover / retention of staff
- ⇒ Salary surveys and market studies demonstrate parity
- ⇒ Core competency exam / curriculum in place
- ⇒ Basic and Advance curricula are available
- ⇒ Continuing education is provided and attended
- ⇒ Clinical supervision includes an ongoing assessment of individual competencies and growth

Objective 1: Enhance recruitment and retention of professionals qualified specifically to treat persons with co-occurring disorders

Strategies:

- a) Provide ongoing training in the treatment of co-occurring disorders, cultural competency, etc.
- b) Develop and implement a recognition program for persons trained specifically for providing integrated treatment services

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- c) Define competencies
- d) Allow long term transition of implementing new training and competency levels
- e) Develop partnerships with universities and other educational institutions
- f) Provide incentives for personnel based on experience, expertise and performance
- g) Develop a certification program with defined requirements for treating persons with co-occurring disorders

Objective 2: Provide appropriate compensation for the provision of integrated treatment services.

Strategies:

- a) Reach parity with the private sector in employee related benefits
- b) Provide advancement opportunities for growth, salary increases and benefits based on competency and experience.
- c) Define and adhere to manageable workload standards.

Objective 3: Provide initial and ongoing training opportunities.

Strategies:

- a) Create collaboration between agencies to determine level of competence required
- b) Establish minimum level of competence across system resulting in intra-agency collaboration. This requires broad knowledge on a wide array of areas for generalists
- c) Provide basic substance abuse assessment / mental health assessment training

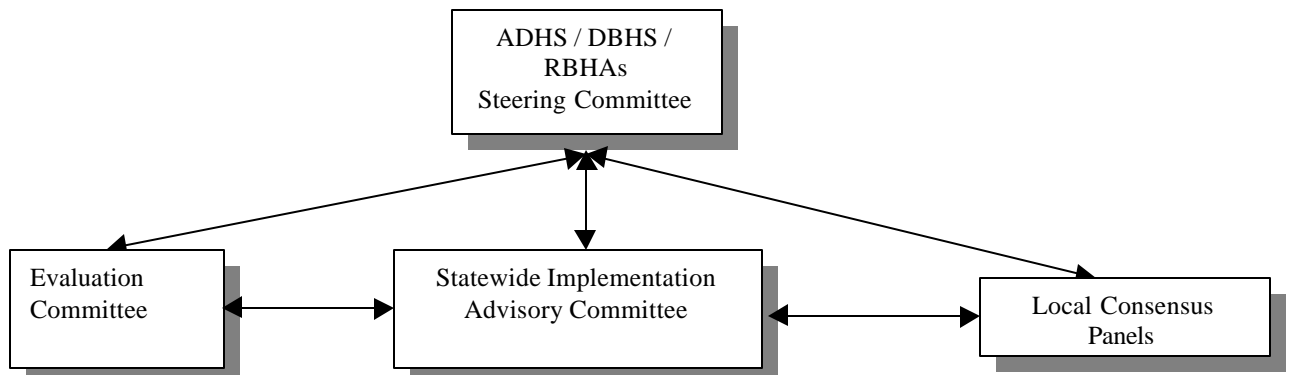
IMPLEMENTATION RECOMMENDATIONS

Implementation Structure

1. ADHS will include the implementation of the integrated treatment recommendations in the Regional Behavioral Health Authority contracts and RBHAs will include the implementation of integrated treatment in provider / network contracts.

Prior to forming a Steering Committee, ADHS will begin the implementation and education process with the RBHAs. Part of this process will be introduction of the treatment planning guidelines.

2. Create a Implementation Steering Committee comprised of ADHS, RBHA to begin the education and information dissemination processes, to establish and maintain the ongoing implementation structure and to implement the recommendations of the Consensus Panel.
3. Create a Statewide Implementation Advisory Committee to provide advice to ADHS and the RBHAs regarding implementation of the recommendations, monitor the changes in best practice, and to serve as a focal point for information exchange across the state.
4. Membership should include key stakeholders, ADHS, Regional Behavioral Health Authorities, the Arizona State Hospital, providers of mental health services, providers of substance abuse treatment services, consumers, family members, representation from rural and urban areas of the state, minority cultures, the Administrative Office of the Courts, the county jail systems, parole and probation representatives, county hospitals and Department of Corrections.
5. Create Local Consensus Panels to provide a forum for identifying and resolving local implementation issues, monitoring implementation of the recommendations, refining and updating the recommendations as needed, and exchanging knowledge and experience regarding implementation of the Plan. Local Consensus Panels should include key stakeholders as identified in item 4 above.
6. Create an Evaluation Committee to develop a detailed evaluation plan and pursue funding for implementation of evaluation activities related to integrated treatment.



Stakeholder Involvement

To ensure ongoing stakeholder involvement continues, and to increase the number of individuals involved in and aware of the importance of integrated treatment, the following specific actions are recommended:

1. Ensure consumers and family members are included in the Statewide Implementation Advisory Committee, Evaluation Committee, and Local Consensus Panels.
2. Consumer and family member representation from each of the RBHAs needs to be present on the Statewide Implementation Team.
3. Create a Speakers Bureau to provide information to a variety of organizations about integrated treatment and this Implementation Plan.
4. Create a written presentation package, video and slide presentation that can be provided upon request to any individuals or organizations requesting information about Integrated Treatment.
5. Send the Panel products to all Stakeholders. Identify the Key Stakeholders and call them first to say we are sending the information.
6. Plan and schedule statewide regional forums to include providers, consumers, family members and advocates to seek input to the Implementation Plan and to further the concepts of integrated treatment.
7. Promote buy-in from the providers, other state agencies (DES, Parole, Probation, Education), the Faith Community and the RBHAs before approaching policy makers.
 - Introduce the ideas at the RBHA provider meetings first
 - Schedule special presentations.
8. Provide training and education opportunities on an ongoing basis for provider agencies, consumers, family members, and advocates. The training and education events should include a description of integrated treatment and why it is important, identification of the integrated treatment services now available, what the next steps are in implementation, and how to become involved.
9. Provide opportunities to increase legislative awareness and education.

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Funding

1. ADHS/DBHS is in the process of submitting a budget request to the legislature. If additional funding is received, the integrated treatment principles will be built into the requirements for additional services that will be developed as a result of this funding.
2. ADHS/DBHS will pursue a SAMSHA Implementation Grant in order to continue the activities of the work groups. Grants are selected and competitively awarded from the projects proposed by the Consensus Panel grants.
3. ADHS/DBHS will continue to seek ways to fund educational experiences for staff who are working with individuals with co-occurring disorders. ADHS/DBHS will use grant carry over funds to contract with the University of Arizona to provide training for line staff throughout the next year.
4. Develop creative financing models that allow for blended funding to treat co-occurring disorders.
5. The ADHS/DBHS work group that was exploring funding issues determined that the problem with joint funding for individuals with co-occurring disorders begin in the claims processing procedures. The group will continue to explore this issue and will develop a solution to be presented at a future meeting.
6. Identify individual and network costs associated with treatment of co-occurring disorders.
7. Design benefit packages and financing models that parallel the continuum of severity.
8. Ensure accountability for funding streams within the context of co-occurring treatment.
9. Issue guidelines that address real and imagined funding restrictions.
10. Develop guidelines to support ethical delivery of co-occurring treatment to all behavioral health populations.

Evaluation

1. Establish an Evaluation Committee
2. Identify existing Arizona data regarding integrated treatment
3. Make recommendations regarding an Agency Self Assessment Process
4. Pursue a research grant(s) to measure individual and system outcomes.
5. Identify best practice strategies in the integration of treatment services and provide current information to the Implementation Team.

6. Implement the Gain Center Assessment of Integrated Treatment
7. Monitor the results of the Integrated Treatment Pilot Programs started in FY 99.

The Continuum of Care

Philosophy

There should be no difference in approach to persons presenting for services in the Arizona behavioral health system, regardless of whether they are presenting for treatment of a mental or a substance abuse disorder. Persons presenting for treatment should be presumed to be at risk for co-occurring disorders, unless assessment proves otherwise. Persons who are determined not to have co-occurring disorders of mental illness and substance abuse can then be treated in the manner determined to be clinically appropriate.

The Continuum of Care should provide persons with co-occurring disorders the opportunity and ability to pass from one level or locus of treatment with supports to another. The Continuum will emphasize the concept of appropriate level of care of treatment, as opposed to “failure”, when a person needs to move from one locus of treatment and support to another. Concurrently, treatment programs and services should not be rigidly time-limited or limited to a strict progression from one phase to another. For example, the length of stay in a residential treatment should be individually based, rather than program-based. Within the Continuum of Care, shelter and housing should be provided with varying levels of supervision, depending on the needs of the individual client.

Individuals will be enrolled in a treatment process that addresses co-occurring disorders. The individual will have a single person or clinical team to manage his or her care within the treatment system. Treatment and support services for persons with co-occurring disorders need to be based on specific individual assessment and diagnosis, utilizing best practices geared to specific desired outcomes.

A successful Continuum of Care requires partnerships between and among mental illness and substance abuse treating agencies, the criminal justice system, behavioral health system administration, vocational rehabilitation agencies, as well as government and private funding sources. The goal is to create a flexible continuum of treatment programs and services. The service array offers a mix of treatment strategies, including harm/use reduction and abstinence. The service array assures a continuum of services that addresses the needs of persons with co-occurring disorders.

The Continuum of Care should strongly support client involvement, as appropriate, in self-help, natural supports, and community based resources as essential to promoting improved functioning. The Continuum of Care should be flexible to respond to change based on periodic review of research and evaluation of “best practices.”

Recommendations

A. Increasing *cultural competency* is a major “component” of the Continuum of Care. While there is no commonly held definition of cultural competency, the US Department of Health and Human Services defines cultural competency as:

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“ A set of behaviors, attitudes, and policies that come together in a system, agency, or program or among individuals, enabling them to function effectively in diverse cultural interactions and settings. It promotes an understanding of cultural differences and similarities within, among, and between groups. Cultural competency is a goal of all systems, agencies, programs, and individuals continually aspire to achieve.”

A culturally competent system is characterized by:

- ◇ Provider location in ethnically identifiable neighborhoods
- ◇ Accessible and understandable literature for diverse patients
- ◇ Ethnic diversity among providers
- ◇ Provider ability to speak the client's language
- ◇ Provider participation in cultural competency training
- ◇ Coverage of alternative medicine interventions
- ◇ Consideration of cultural beliefs and needs that may affect the type of intervention used when applying criteria for determining medical necessity
- ◇ Access and utilization performance measures specifically geared toward measuring access by identifiable populations
- ◇ Culturally competent administration
- ◇ Interpreter services
- ◇ Performance measurement
- ◇ Emphasizes Traditional Treatment (Traditional to a particular ethnic or cultural minority)

See Goal D, Objective 4 in the Long Term Plan Section

B. A *full continuum of care* will offer a comprehensive service array provided through culturally responsive components at all levels of care. At a minimum, the comprehensive system continuum of care for adult persons with co-occurring disorders of mental illness and substance abuse should include levels of care, components, and services, that are consistent with the criteria specified by American Society for Addictive Medicine.

Acute or Intensive Services including:

1. Outreach/Case finding
2. 24-hour integrated psychiatric and substance triage and assessment capacity.
3. Integrated psychiatric and substance disorder crisis intervention and crisis counseling
4. Crisis stabilization beds which can accommodate substance involved individuals in mental health crisis.
5. Acute psychiatric inpatient beds, with dual diagnosis assessment and stabilization capacity.
6. Integrated psychiatric and addiction or dual diagnosis specialized acute psychiatric units.
7. Intermediate or long-stay psychiatric inpatient beds for severely mentally ill consumers with co occurring substance disorders.
8. Acute detoxification programs, which can accommodate psychiatrically unstable addicted individuals.
9. Substance dependence residential rehabilitation programs, which can accommodate individuals with stable, comorbid psychiatric conditions.
10. Psychiatrically-enhanced or dual diagnosis residential substance abuse rehabilitation programs, for unstable individuals.
11. Integrated partial hospitalization programs, for acute stabilization of psychiatric and substance disorders.

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12. Addiction day treatment and intensive outpatient programs, with capacity to accommodate consumers with stable psychiatric illness.

Outpatient Services including:

1. Family Education Services
2. Early Intervention (ASAM Criteria 0.5)
3. Detoxification
4. Aftercare
5. Psychiatric day treatment/clubhouse/rehabilitation programs with dual diagnosis programming for individuals with co-occurring disorders.
6. Integrated intensive continuous case management services (individuals or teams) for all types of dual diagnosis consumers (not just persons with serious mental illnesses.).
7. Outpatient services incorporating integrated mental health and substance abuse treatment capacity including:
 8. Mental health and substance use disorder assessment.
 9. Individual / family case management and case coordination.
 10. Individual treatment.
 11. Psychopharmacologic assessment and treatment.
 12. Group treatment, e.g., engagement/persuasion, active treatment, psychoeducation, relapse prevention groups.
 13. Family treatment, including, individual and group psychoeducation, and peer support.
 14. Rehabilitation counseling, including living skills to social skills training.
 15. Peer counseling, and peer support groups.
 16. Vocational Rehabilitation
 17. Opiate Maintenance Therapy

Residential Treatment Services including multi-levels of services:

1. Addiction halfway houses, therapeutic communities, and sober houses, with capacity to accommodate individuals with psychiatric illness (but not severe disability).
2. A psychiatric residential continuum for consumers with serious mental illnesses (group homes, safe havens, and supported housing models) which incorporates stages of recovery, recognition, and assessment.
3. Sober housing, with case management services, for persons with co-occurring disorders
4. Modified therapeutic communities for persons with co-occurring disorders.
5. Sober psychiatric group homes and recovery programs for persons with co-occurring disorders.
6. "Wet" and "Semi-Wet" Housing

Services to be provided in the Continuum of Care

The following services should be funded and provided by the Arizona behavioral health system (see glossary for full description):

1. Alternative Residential Facilities
2. Assessment/Evaluation -
3. Behavior Management -
4. Case Management Services -
5. Crisis Services -
6. Consumer-Run Services

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7. Detoxification
8. DUI Education - Services provided to educate DUI offenders
9. DUI Screening - Services provided to screen DUI offenders for the presence of alcohol or drug abuse and related problems using standardized tools and criteria
10. Education Services
11. Family Therapy & Counseling -
12. Group Therapy and Counseling
13. Individual Therapy and Counseling
14. In Home and Community Services
15. Inpatient Hospital/Inpatient Acute Care
16. Inpatient Psychiatric Facility for Persons Under 21 Years of Age/Residential Treatment Center
17. Laboratory, Radiology and Medical Imaging
18. Partial Care, Basic
19. Partial Care, Intensive
20. Pre-petition Screening, Court Ordered Evaluation and Treatment
21. Prescription Medications and Pharmacy
22. Prevention Services
23. Psychosocial Rehabilitation
24. Psychiatric Nursing Services
25. Psychiatric Services
26. Psychological Services
27. Residential Services
28. Respite
29. Screening
30. Integrated Treatment for Co-occurring Disorders - An array of structured interventions to reduce or eliminate abuse and dependence on alcohol and other drugs and to address other adverse conditions related to substance abuse. Interventions are provided in a range of outpatient, inpatient and residential settings and (can) shall include detoxification, methadone maintenance, recovery support services. and prevention and education services for the consumer and family, provided in a manner integrated with treatments of other mental/ behavioral health problems.
31. Supported Housing Services
32. Transportation
33. Vocational Rehabilitation Services

Implementation Actions

1. Based on the identified proposed continuum, identify what services and in what quantity are currently available, estimate the need by service and identify the priority areas for development.
2. Identify and resolve licensing or other regulatory barriers to building the continuum.
3. Develop guidelines / protocols for managing treatment plans across multiple agencies and levels of care.
4. Define how the services in the continuum can be organized into a treatment model. How is it determined who receives what level of service?
5. Develop / define models for implementation based on current data and information available. Allow for the development of local models based on a set of required outcomes.

Competencies & Training

Key Steps to Implementation

1. Continue with coordination of January Training with Dr. Minkoff and Dr. Mueser sponsored by the National GAINS Center. This is not intended for ITCP members to attend. Discussed that the training should be focused on individuals who can implement program and/or policy change (not direct staff).
2. Define staff in the Competencies Matrix to include specific job tasks and responsibilities (developing vs. implementation of plan) cross check against PBHP requirements, accreditation standards, licensure requirements and other contractual/regulatory obligations.
3. Develop a plan to educate and obtain support from practitioners, consumer groups, advocacy groups, (AAMI, MHS, CAB), legislators and other community stakeholders.
4. Assess current trainings that are being provided through the RBHAs and gather information about how to roll-out training statewide.
5. Explore RFP requirements and discuss with RBHAs credentialing requirements for provider agencies.
6. Assessment of needs -"cold numbers" on nature of problems-(Public Research Collaborative (PRC) initiative-agency by agency) including # of agencies, staff, types of training, dollars, etc.
7. Explore additional resources and/or foundations such as St. Luke's, grants, AAMI, MHS to sponsor, fund or provide scholarships for training.
8. Coordinate with PRC Initiative Grant and TOPPSII to collaborate the training institute/programs, resources, use of national experts (dual diagnosis track to programs), etc.
9. Define responsibilities of agencies, RBHA and State to provide and/or fund training programs.
10. Set up a meeting with the Office of Behavioral Health Licensure (OBHL) to discuss the need for required training of Co-occurring Disorder and an additional classification that would include individuals that did not have a degree but have experience and training (e.g. peer counselors). Obtain clarification regarding agency requirements for credits vs. classroom hours. Discuss with OBHL the time frames and how new training requirements would be implemented if agreed upon.
11. Inventory of current expertise in the state (consultants, trainers, etc.).
12. Develop a plan prioritizing target groups and topics to be implemented/required first.
13. Develop training modules to be implemented statewide.

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14. Step up specific outcomes for each phase of implementation for example 80% trained by 2004.
15. Review curriculum from different universities and community colleges (U of A Dual Dx. Program).
16. Expanding training to prevention approach i.e. connecting with medical providers (VO Prevention Contract).
17. Explore through the Board of Behavioral Health Examiners, certification and credentialing requirements.

Recommendations:

The following actions must be taken to further define and implement the Competency Recommendations:

1. Identify options for establishing an additional certification or privileging category that would include individuals that did not have a degree but have experience and training (including work experience and life experience-for example peer counselors).
2. Incentives should be provided for staff who have additional training and skills i.e. salary, scholarships for additional training/education, tuition reimbursement, hiring preferences, training requirements to be included in supervision/evaluation of staff performance.
3. Diversified responsibilities and funding of training (for example orientation type training to be provided by the RBHA or provider agencies, statewide training (modules) developed by the DBHS, Master or above educations would be considered career development which is the responsibility of person)
4. Implementation of new training requirements should include grand fathering and allow for a transition period of new contract requirements parceled out over several years-(consider differences for rural vs. urban providers)
5. Should have various types/levels of training including orientations, training of the trainers, classroom training, Community College Programs, University Programs, multi-media and importance of mentoring/modeling behavior (hands on approach-direct clinical supervision). Consider development of modules to made available to RBHA.
6. Consider development of centralized university programs that offers compressed curriculums and/or distant education (very important for rural areas).
7. Important that all levels in the continuum of care and the various levels of staff in each setting have the required training.

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8. ADHS, RBHAs and advocacy organizations should develop partnerships to provide funding for development of training, the delivery of training and related technology (grants, AAMI, MHA, Consumers)
9. Video modules need to be developed for intro/orientation of all staff & to ensure consistency
10. Academic programs should include training requirements to include Integrated Treatment Principles and Practice
11. Testing out - options for should be available for lower level course work (orientations)
12. A process for re-certification should be required for certain topics such as medications/ psychopharmacology and best practice
13. Competency based assessment of skills-not just testing after completing a training (Supervised Practice)
14. Evaluate possibility over the next couple of years the option of a formal credentialing or privileging program for Integrated Treatment
15. Contract requirements and provider privileging should require minimum training expectations
16. Licensing to include staff required training related to co-occurring disorders
17. Explore partnering with accreditation programs
18. Interface between agencies and integrate training programs for all case managers - not just all SMI Case Managers

Preliminary Barriers Identified and Options to Address

- Cost/funding for training programs (partnerships, grants, streamlining funding)
- Vast number of individuals who require training (grand fathering, setting priorities, realistic time frames, convenient training, flexibility in delivery mechanism)
- Resistance to change & getting support from academics, professionals, consumer, advocacy -(education, promotion, incentives and interfacing with staff from SA and MH-joint training)
- Employee market and trainers market (work with current academic programs, speakers bureau, inventory of current resources, trainers consortium)
- Providers feeling that they must do more without more money-motivating (training management structure-CEOs, CFO, -bring out the benefits, outcomes and financial benefits, service costs)
- Stimulate market to do this while changing requirements of licensure (training, benefits of change, incentives)
- Separate funding streams-limited ability to get additional funds (explore alternative funding sources and partnerships)
- Staff helplessness - trainings occur but service delivery system not yet available (timeliness of implementation of the continuum of care)

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- Managed care and specializing populations-longer treatment, required engagement and outreach with no additional funding (training, define benefits, hallmarks of success and incentives)
- Lack of facilities to do long term treatment (explore options of continuum of care, modifying current programs, implementation plan)
- Consistency of training messages and information (muti-media and distant training programs)
- Differences between self help model and treatment model-philosophical-how to bridge the gap-harm reduction (good clinical mentors and training-integrated training programs for SA and MH providers))
- Lack of integrated credentialing currently in existence through the RBHAs (explore with RBHAs current practice and implications of changing current system)
- Unrealistic expectations-system and the person (implementation, use of national performance measures coordinate with TOPPII)
- Bench marking Arizona outcomes and linking funding requests to those outcomes Behavioral Health Board of Examiner-time to process (explore changes to current process - develop a partnership with agency)

Competencies and Skills Matrix

The following matrix identifies the staff level which needs specific competencies and training (top row) and the category of competencies/skills needed (left column) and the specific competencies needed for each staff level by category of competencies. For example, R1 under support staff for Relational Skills means: *compassion, empathy, respect, flexibility and hope to all individuals, regardless of their degree of inpatient, stage of (non)recovery, or level of cooperation in their treatment and recovery process*. The definitions of the competencies/skills are listed following the matrix.

Staff Level→ Competencies/ Skills	A. Support Staff (receptionists, van drivers)	B. Direct Services I PLUS A	C. Direct Services II (case managers- service planning) PLUS A&B	D. Clinical Supervisors (MD, RN, CCC) PLUS A,B&C
Relational Skill	R1, R2, R3, R4 (welcoming only), R8	R4 (collaborators) R5, R6, R7,		
Technical (Knowledge Based) Skills - K15 Need clarification	K1, K2, K12	K3-K10, K16 (general overview)	K11, K13, K14, K16 (how to do it)	
Assessment Skill	A6	A1,A2,A6,K17	A3,A4,A5,A7,A8	
Treatment Planning Skill		P4	P1-P4	P1-P4
Treatment, Rehab., & Recovery	T1,T5,T10 (Familiarity Only)	T2,T3,T4,T6,T 11		

COMPETENCIES REQUIRED FOR PRACTICE

A practitioner who works directly with persons having dual or multiple disorders is able to demonstrate consistently:

Relational Skills (based in values and attitudes):

- R1 compassion, empathy, respect, flexibility and hope to all individuals, regardless of their degree of inpatient, stage of (non)recovery, or level of cooperation in their treatment and recovery process;
- R2 objective, empathic detachment, and willingness to become conscious of and manage personal biases. maintaining a non-judgmental, non-punitive demeanor and approach;
- R3 sensitivity to, and respect for, persons with different disorders, characteristics. and cultural backgrounds. e .g ., ethnic, racial, gender, sexual orientation, and socio-economic class;
- R4 the capacity to have persons, family members, and other service providers feel truly welcome as collaborators, even, and especially, under difficult circumstances;
- R5 desire and willingness to elicit the person's viewpoint and to regularly validate the daily courage needed to survive the ravages of multiple no-fault persistent and relapsing disorders;
- R6 patience and persistence in helping to establish and maintain the person's motivation, comfort in accepting one's inability to control another's behavior, and caring acceptance of the person's perceived need to be dishonest with self and others;
- R7 capacity to maintain one's professional boundaries, to disagree without being controlling or punitive, to be clear without being harsh, and to maintain consistency in one's approach and demeanor;
- R8 the ability to communicate with integrity and honesty, clearly and concisely, both verbally and in writing, in a manner that respects the dignity of all, and that is focused on what all team members need to know.

Technical (Knowledge-Based) Skills:

- K1 familiarity with categories within, and use of, the current edition of the DSM as a means of reviewing current diagnostic criteria and related features of all disorders described' therein;
- K2 familiarity with current DSM diagnostic criteria for substance-related disorders. including distinctions between substance use, abuse and dependence, and classes of chemicals. including their basic actions in the body and brain, their intoxication and withdrawal symptoms, and their potential interactions;

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- K3 familiarity with current DSM diagnostic criteria for Axis I and II mental disorders, including psychotic, affective, and anxiety disorders, with all clusters of personality disorders, and with associated epidemiological features;
- K4 comprehension of the effects on functioning and degree of disability related to substance related and mental disorders, both separately and combined;
- K5 knowledge of the classes of psychotropic medications, their actions, medical risks, side effects, possible interactions with other substances, and addictive potential;
- K6 attempts to continually learn about new psychoactive chemicals (prescription, non-prescription, and street drugs) and to educate others about what is learned,
- K7 familiarity with the signs and symptoms of potentially high-risk medical complications associated with detoxification, with the use of psychotropic medications, and with interventions needed, e.g., prompt referral to medical personnel/services;
- K8 familiarity with integrated models of assessment, intervention, and recovery for persons having both substance-related and other mental disorders, as opposed to parallel treatment efforts that resist integration,
- K9 familiarity with the history of treatment and support services in the mental health and drug/alcohol service systems, including ongoing barriers to service integration and current efforts at integration;
- K10 familiarity with data which support high prevalence of comorbidity and poor outcomes related to fragmented treatment approaches, as well as data demonstrating improved outcomes related to integrated continuous treatment approaches;
- K11 familiarity with, and use of, stage of recovery models when applied to assessment, service planning, selection of treatment and/or support modalities, and expectations of the degree to which the person is active and collaborative in the direction of his/her treatment and responsible in directing his/her own recovery;
- K12 knowledge that relapse is not considered a failure but an opportunity for additional learning (for the person and all involved), and displays patience, persistence, and optimism;
- K13 familiarity with, and use of, a variety of interventions, modalities and services according to their appropriateness for specific individuals and families at specific times in the recovery journey,
- K14 the capacity and willingness to educate persons and family members about what is currently known about specific disorders and more/less useful means of managing them;
- K15 knowledge of the legalities (statutory and regulatory) related to each disorder and treatment setting and the local, state and national advocacy activities and services that may be available to assist the person:

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- K16 knowledge about, and use of the full range of entitlement programs and existing services and supports, and how to individualize their use to help a person meet the demands of daily life and reduce stressors from these sources
- K17 knowledge of the purposes and techniques of program outcome evaluations.

Assessment Skills:

A practitioner who works directly with persons having dual or multiple disorders is able to demonstrate consistently:

- A1 the use of strengths-based interviewing and focus in the treatment process;
- A2 knowledge of the biopsychosocial components of assessment, including the spiritual dimension, when assessing both psychiatric and substance-related disorders;
- A3 knowledge about human developmental stages across the life span and capacity to assess the extent to which developmental tasks may have been mastered or neglected;
- A4 the use of comprehensive, integrated and longitudinal assessment data for any assessment, incorporating information from all significant others--family and service providers;
- A5 the capacity to use established criteria for assessing acuity of symptoms and service intensity needs and to define any circumstances that may affect such judgments, including, but not limited to: special medical needs or other disabilities, presence and degree of forensic/legal involvement, etc; (use of ASAM criteria for dually diagnosed)
- A6 the ability to assess acute levels of dangerousness being aware of the high risks for suicide and violence in persons with combined mental and substance-related disorders. and to arrange for safe and medically appropriate interventions when deemed necessary;
- A7 ability to ascertain, from the client, the status of the clients needs and priorities (or ongoing treatment implementation and modification);
- A8 ability to use documented assessments for program outcome evaluations

Treatment Planning Skills:

- P1 the ability to collaboratively develop and implement an integrated treatment plan (or integrated service plan when case management or community treatment teams are needed), based upon thorough and ongoing assessment, that addresses both/all disorders and establishes sequenced goals based on most urgent needs, considering the stage of recovery and/or level of engagement;
- P2 the ability to involve the person, family members, and other supports and service providers. in a collaborative process for establishing, monitoring, and refining the current treatment plan;

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- P3 the ability to identify and access a full range of treatment and support services, including peer supports and those in the natural support system;
- P4 the ability to involve the person in active choices, goal-setting, use of therapeutic contracting, and other activities which support the person's capacity to envision a positive personal future.

Treatment. Rehabilitation and Recovery-Focused Skills:

A practitioner who works directly with persons having dual or multiple disorders is able to demonstrate consistently:

- T1 familiarity with, and use of, integrated, continuous case management and/or community treatment teams for persons needing such support;
- T2 attempts to solicit feedback from the person, family members and/or others in the immediate support network, about the perceived effect of prescribed medications and any concerns that they may have;
- T3 attempts to engage the person and involved others in discussion of deviating from prescribed use of medications and/or use of alcohol and/or street drugs in terms of the meaning of such use for the person and the perceived benefits/penalties of such use or non-use;
- T4 familiarity with, and use of, current intervention techniques such as, but not limited to: motivational enhancements, behavioral contracting, empathic confrontation, cognitive--behavioral approaches to both treatment and relapse prevention, skills and social skills training, psychoeducational individual and group approaches;
- T5 familiarity with, and use of, interventions designed to aid in the recovery of persons with traumatic histories and co-occurring disorders;
- T6 the capacity to engage family members and offer various supports on an individual and group basis (e.g., education, peer support, referrals for needed social services, family psychoeducation or therapy where indicated and desired) and to refer to such external supports as NAMI and its family education and support group affiliates.
- T7 willingness to learn to use various group approaches for persons in various states of recovery (e.g.: engagement, persuasion, treatment issues, relapse prevention) with varying cognitive abilities, and with differing combinations of co-occurring disorders, such as substance dependence and borderline personality disorder;
- T8 knowledge about, and use of, peer support and empowerment groups, both those aimed at dual recovery and those that support the person in a specific acute area of need (such as a drop-in center, a clubhouse, AA/NA/Double Trouble);
- T9 support of quality improvement efforts, including, but not limited to: consumer and family satisfaction surveys, accurate reporting and use of outcome data participation in the

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selection and use of quality monitoring instruments, and attention to the need for all staff to behave respectfully and collaboratively at all times;

- T10 belief in the ability of all persons to learn and grow, including the practitioner's need to refrain from dogmatism of any sort and to maintain flexibility and the willingness to learn from consumers, family members, colleagues new scientific publications, program data, and life experience;
- T11 willingness and ability to advocate for needed services such as after-hours safe activities, peer-sponsored or other 24-hour crisis services, and attention by funders and insurers to the needs of persons with serious and multiple DSM diagnoses.

Policy and Procedures

Recommendations:

1. No changes in the SMI *Determination Policy* or the *Service Level Determination Policy* are recommended
2. The *Covered Services Policy* and the *Service Planning Guidelines Substance Dependence and/or Abuse* be revised as per the following:

Covered Services Policy include specific language to ensure that consumers who have co-occurring disorders would be able to receive the services they need. See Appendix D

3. *Service Planning Guidelines*. Be revised in accordance with the changes identified in the following section. See Appendix D
4. An ongoing process be developed to review policy and rules of ADHS, RBHA, and Networks as well as Behavioral Health Licensing Rules.

